

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08319

8339

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>QUEEN ANNE</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHESTER</i>		b. COUNTY <i>QUEEN ANNE</i>	
c. LENGTH OF STAY IN 1b <i>CHESTER</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHESTER</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MADISON</i>	Middle <i>E</i>	Last <i>BROWN SR.</i>
4. DATE OF DEATH	Month <i>JULY</i>	Day <i>30</i>	Year <i>1959</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 18-1875</i>
9. AGE (In years last birthday) <i>83</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>83</i>	Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED FARMER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>GEORGE BROWN</i>	14. MOTHER'S MAIDEN NAME <i>MOLLIE WALTERS</i>	Address <i>CHESTER MD.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>	16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>LEONARD BROWN</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>600.0</i> <i>acute uremia</i> DUE TO <i>acute Pyelonephritis</i> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i></span> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Generalized Arteriosclerosis</i> <span style="float: right;"><i>3 weeks</i></span> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Benign prostate hypertrophy</i> <i>Several years</i> <i>Paralysis</i> <span style="float: right;">15 years</span> <i>15 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>5 years</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Stevensville</i>
20f. (City or town) <i>Stevensville</i>	(County) <i>Md.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>March 10, 1940</i> to <i>July 30, 1959</i> , that I last saw the deceased alive on <i>July 29, 1959</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Stevensville, Md.</i> DATE SIGNED <i>July 31, 1959</i>			
ACTUAL SIGNATURE <i>Theodor Sattelmair</i>	PHYSICIAN'S NAME (Type) <i>Theodor SATTELMAIER STEVENSVILLE, Md.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>Aug. 1</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>STEVENSVILLE</i>	22d. LOCATION (City, town, or county) <i>STEVENSVILLE</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i>	ADDRESS <i>Church Hill Md.</i>	24a. REC'D BY REGISTRAR DATE <i>Aug 7 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18320

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar for burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Queen Anne's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Wye Mills</b>		c. LENGTH OF STAY IN 1b <b>none</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Church Hill</b>		d. STREET ADDRESS <b>None</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Beverley Ann Conley</b>		First	Middle	Last	4. DATE OF DEATH <b>July 14 1959</b>	Month	Day	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 17, 1942</b>	9. AGE (In years from birthday) <b>16 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>school</b>		11. BIRTHPLACE (State or foreign country) <b>Church Hill, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Griffin Conley</b>				14. MOTHER'S MAIDEN NAME <b>Hattie M. Ervin</b>		Address <b>Griffin Conley Church Hill, Md.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>824-10-1234</b>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe intracranial damage</b> DUE TO <b>crushing injury to base of skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		
						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>		
						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>		
20a. EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Thrown from moving car on highway against post</b>						
20c. TIME OF INJURY Hour <b>10.45 p. m.</b>		Month, Day, Year <b>7-14 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>highway</b>	20f. (City or town) <b>nr. Wye Mills</b>	(County) <b>Q. A. Md.</b>	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>C. R. Layton</i>		DATE SIGNED <b>7-15-59</b>						
EXAMINER'S NAME (Type) <b>C. R. Layton</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-17-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Church Hill</b>		22d. LOCATION (City, town, or county) <b>Church Hill, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaire Greensboro, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUL 20 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Cathie L. Krasse</i>		

115901  
ИТАЛЫ СО СТАРИЧЕСКИМИ МАСТАВАМИ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18321

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

QUEEN ANNE MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SUDLERSVILLE

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

BLACKISTON NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

b. STATE

MARYLAND QUEEN ANNE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SUDLERSVILLE

3. NAME OF  
DECEASED  
(Type or print)

First MABEL G Middle Green Last

4. DATE  
OF  
DEATH

JULY

24

1959

5. SEX

FEM

6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

JULY 5-1887

9. AGE (In years  
last birthday)

72 yrs.

10. IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

DELAWARE

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN FLEMING

14. MOTHER'S MAIDEN NAME

ELLA FORAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

MR. FRANK GREEN CHURCH HILL

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

331X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

MEDICAL CERTIFICATION

20c. TIME OF INJURY

Month,

Day,

Year

Hour

a. m.

p. m.

19

20d. INJURY OCCURRED  
While  
at work  Not while  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 2, 1959, to July 24, 1959, that I last saw the deceased  
alive on July 21, 1959, and that death occurred at 1146 30th St. M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or county)

(State)

BURIAL

JULY 27

CHURCH HILL

CHURCH HILL

MD.

CREMATION

REMOVAL

SPECIFY

EDGARDIAN

CHURCH HILL MD.

ADDRESS

Central European  
Central European  
Central European

~~missed~~ Imperial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician and completed in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8342

### CERTIFICATE OF DEATH

118322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kings town		c. LENGTH OF STAY IN lb 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD out of Chestertown		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RFD out of Chestertown in Kent Co.	
3. NAME OF DECEASED (Type or print) Hans C. Hanson		d. STREET ADDRESS	
4. DATE OF DEATH 7/19/59		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1869
9. AGE (In years last birthday) 90		10. IF UNDER 1 YEAR Months 0 DAYS 0 Hours 0 Minutes 0	
11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Hanson		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Warden F. Yost		Address Chestertown, Md. RFD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)			
DUE TO Congestive heart failure DUE TO Atherosclerotic heart disease			
INTERVAL BETWEEN ONSET AND DEATH months years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1958, to 19 July, 1959, that I last saw the deceased alive on 19 July, 1959, and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE HARRY PAUL ROSS M.D.		ADDRESS (Street, city or town, state) 203 N Queen St Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/59	
22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Willis Wells		24a. REC'D BY REGISTRAR DATE JUL 21 '59	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8343

## CERTIFICATE OF DEATH

Reg. Dist. No.

108323

1. PLACE OF DEATH a. COUNTY <b>Queen Anne's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barclay</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barclay</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas</b>		First <b>M.</b>	Middle <b>Jackson</b>
4. DATE OF DEATH <b>July 3 1959</b>		Month <b>July</b>	Day <b>3</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 10, 1885</b>		9. AGE (In years last birthday) <b>73</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>1</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Hartley, Del.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Andrew Jackson</b>	
14. MOTHER'S MAIDEN NAME <b>Frances Ann Cahall</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>1918</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Maude R. Jackson,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1918</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. <b>(b)</b>			
DUE TO <b>Paroxysms of cough, face &amp; throat</b>			
DUE TO <b>Paroxysms</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>2/2</b>	
20c. TIME OF INJURY Hour o. s. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Barclay</b>
20f. (City or town) <b>Barclay, Md.</b>		(County) <b>Barclay</b>	
(State) <b>Barclay</b>			
21. I certify that I attended the deceased from <b>July 3, 1959</b> , to <b>July 3, 1959</b> , that I last saw the deceased alive on <b>July 2, 1959</b> , and that death occurred at <b>Barclay, Md.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Barclay, Md.</b>	
ACTUAL SIGNATURE <b>C. H. METCALF</b>		DATE SIGNED <b>July 7, 1959</b>	
PHYSICIAN'S NAME (Type) <b>C. H. METCALF</b>		22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>July 6, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Templeville Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Templeville,</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Wellington, Md.</b>		24a. REC'D BY REGISTRAR DATE JUL 7 '59	
ADDRESS <b>Edward Fellows, Wellington, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

FLASH TO STATEWIDE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118324

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transtil permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Queen Anne's</i> MARYLAND		a. STATE <i>Md.</i>	b. COUNTY <i>Anne Arundel</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Rural - Stevensville</i>	<i>2 days</i>	<i>Brooklyn</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>—</i>		<i>339 Cedar Hill Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>William</i>	Middle <i>Frank</i>
4. DATE OF DEATH		Month <i>July</i>	Day <i>17</i>
5. SEX		5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<i>M</i>		<i>W</i>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1YEAR Months <i>63</i> yrs.
<i>Feb. 20, 1896</i>		<i>63</i> yrs.	Days <i>63</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Fireman</i>		<i>Steel</i>	<i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Not Known</i>		<i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
<i>No</i>		<i>Robert J. Leake</i> <i>Box 248 Old Oak Rd.</i> <i>Severna Park, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Mycocardial Infarction</i> <i>Few</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>Coronary Occlusion</i> <i>Minutes</i>	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Irvin G. Hoyt M.D.</i>		<i>7/7/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 20-1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>
22d. LOCATION (City, town, or county) <i>Brooklyn, N.Y.</i>		(State) <i>N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert P. Ware - Glen Burnie</i>		24d. REC'D BY REGISTRAR <i>JUL 21 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>
ADDRESS		DATE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118325

8345

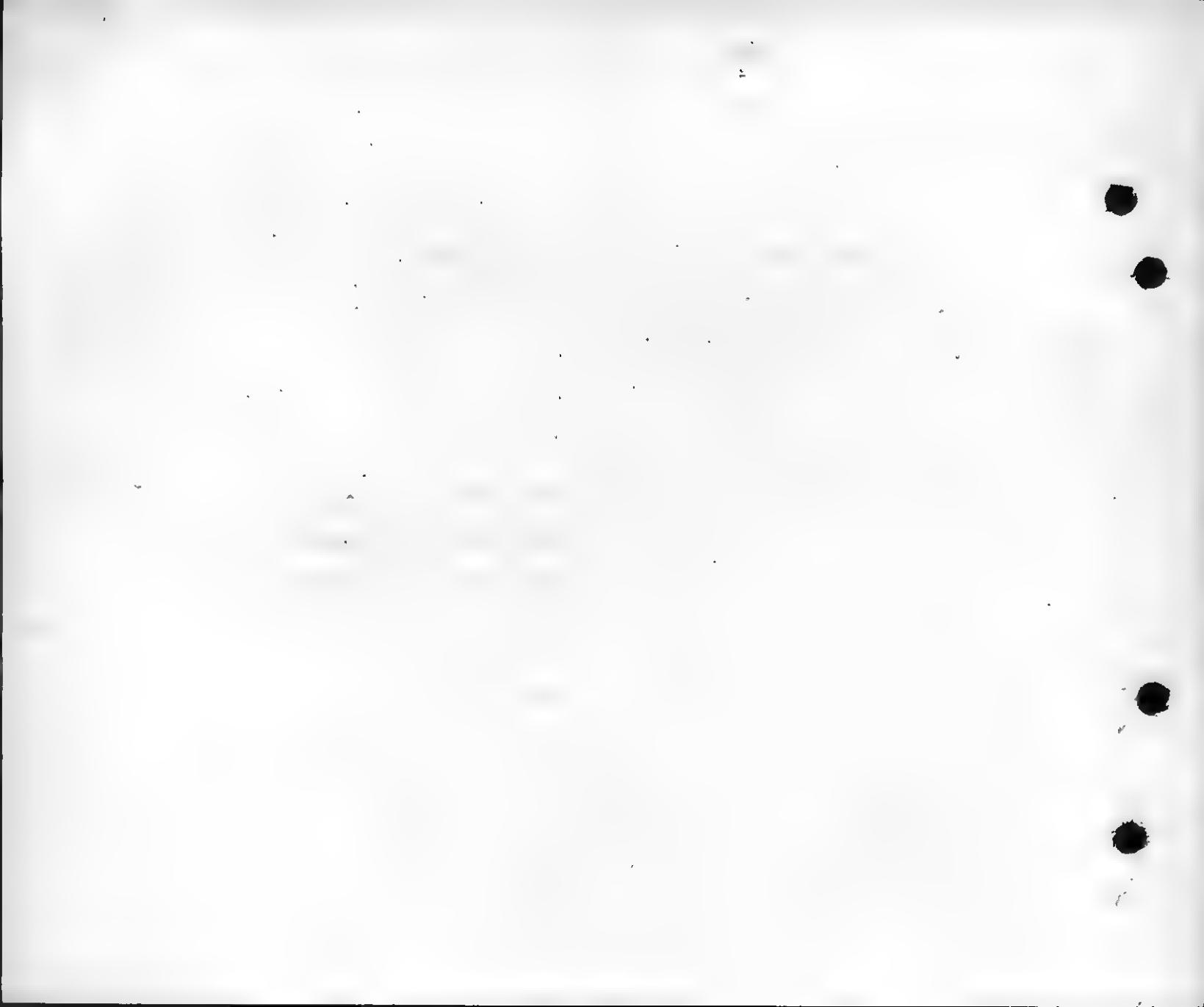
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)	
Queen Anne's MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Centreville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville	
c. LENGTH OF STAY IN 1b 18 yr.		d. STREET ADDRESS 401 S. Liberty St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Nathaniel	Middle Clothier
4. DATE OF DEATH		Month July	Day 20
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 6, 1875		9. AGE (in years last birthday) 84 yrs	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Del.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nathaniel Leverage	
14. MOTHER'S MAIDEN NAME Sally Crother		15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown N	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. LEVERAGE - CENTREVILLE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO Hypertensive, Arteriosclerotic Heart Disease (c) DUE TO Sev. Yrs.		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on		7/8/1959 to 7/10/1959	that I last saw the deceased M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irvin G. Hoyt M.D. 7/21/59
ACTUAL SIGNATURE Irvin G. Hoyt M.D.		22a. BURIAL, CREMATION REMOVAL (Specify) Burial	
22b. DATE THEREOF JULY 23		22c. NAME OF CEMETERY OR CREMATORIUM Church Hill	
22d. LOCATION (City, town, or county) Church Hill Md.		24a. REC'D BY REGISTRAR DATE JUL 23 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove service papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08326

8346

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pondtown, Rural Millington</b>		c. LENGTH OF STAY IN 1b <b>Pondtown, Rural Millington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pondtown, Rural Millington</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pondtown, Rural Millington</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b>		First	Middle	Last	4. DATE OF DEATH <b>PINKNEY</b>	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8, 1885</b>	9. AGE (In years last birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph Pinkney</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Alice Wright, Rural Millington, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4222</b>		DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.</b>		<b>Reuben Newellage</b>		INTERVAL BETWEEN ONSET AND DEATH			
		(b)		<b>Carroll Orbit Polaris</b>					
		DUE TO (c)		<b>Carrie Newellage</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				<b>Lunited</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>W</b>							
20c. TIME OF INJURY Hour a. m. <b>21</b>		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
p. m.									
21. I certify that I attended the deceased from <b>Aug 3</b> , 1959, to <b>Aug 25</b> , 1959, that I last saw the deceased alive on <b>Aug 25</b> , 1959, and that death occurred at <b>11A</b> M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <b>W. W. McFate</b>		M.D.				DATE SIGNED <b>July 3, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Dr C H METCALFE</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>August 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Pleasant Cemetery</b>		22d. LOCATION (City, town, or county) <b>Pondtown, Rural Millington, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Tolson Millington, Md.</b>		ADDRESS		240. REC'D. BY REGISTRAR DATE <b>Aug 3 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Carina S. Knue</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8347 Item 13 Film G244 7-20-59 et

118327

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chester				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First PERCY	Middle A.	Last STALLING	4. DATE OF DEATH	Month July	Day 5	Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20-1886	9. AGE (In years last birthday) 72	10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Stalling		14. MOTHER'S MAIDEN NAME Amelia Jones						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Percy Stalling		Address Chester		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Myocardial infarction, congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 3 days				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) Hypertension Cardis - vascular disease DUE TO (c) Generalized arteriosclerosis with occlusion.		3 years 5 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At		20f. (City or town) Stevensville	(County) (State)	
21. I certify that I attended the deceased from May 10, 1956, to July 3, 1959, that I last saw the deceased alive on July 5, 1959, and that death occurred at 12:05 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Stevensville, Md.	DATE SIGNED July 5, 1959.	
ACTUAL SIGNATURE Theodore Sattelmaier		PHYSICIAN'S NAME (Type) Theodore Sattelmaier		M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7		22c. NAME OF CEMETERY OR CREMATORIAL Stevensville		22d. LOCATION (City, town, or county) Stevensville, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE JUL 13 '59		24b. REGISTRAR'S SIGNATURE Collins L. Phares		

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